Print

# Swedish Urology Group, PC

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## Authorization for Swedish Urology Group to Release My Health Care Information

**Patient Name:**_____ **DOB:** _____

Previous Name: _____

I request and authorize Swedish Urology Group to release my healthcare information to:

_____
Provider's Name

_____
Street Address

_____
City, State Zip

_____
Phone

_____Fax

**You may disclose the following healthcare information (check all that apply):**

☐ All healthcare information in my medical record.

☐ Only healthcare information in my medical record relating to the treatment or condition listed:
_____

☐ Only healthcare information in my medical record from_____(date) to_____(date).

☐ Other information (e.g. lab results, bills, etc.) Specify items and dates: _____
_____

**You may disclose healthcare information regarding testing, diagnosis and treatment for (check all that apply):**

☐ HIV (AIDS Virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders / mental health
☐ Drug and/or alcohol use

**Authorization ends:**
☐ 90 days from the date signed
☐ on (date): _____
☐ when the following event occurs: _____
(not longer than 90 days from date signed)

**My Rights**

- I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or employment).
- I understand that I may revoke this authorization by:
  - Filling out a revocation form available from Swedish Urology Group, P.C. or
  - Writing a letter of revocation to Swedish Urology Group, P.C.
- I understand that revoking this authorization would not affect any actions already taken by Swedish Urology Group, P.C. based on this authorization.

_____ _____
Patient or legally authorized individual signature — Date

_____ _____
Printed mane if signed on behalf of the patient — Relationship (parent, legal guardian, etc.)